TEXAS DEPARTMENT OF STATE HEALTH SERVICES
TEXAS MAMMOGRAPHY PROGRAMS
P.O. Box 149347
Austin, Texas 78714-9347

INDIVIDUAL'S NAME: _____ **MAMMOGRAPHY CERTIFICATION #: M**_____

Interpreting Physician Qualification Worksheet

Submit required supporting documentation.

- *For new individuals –submit all requested documentation.*
- *For accreditation renewals – submit current license and continuing experience and education documentation.*

LICENSURE

____Texas Medical License
(Copy of current license)

INTERIM
(Initial Qualification met before 04/28/1999)

____ABR, AOBR, or RCPSC
OR Two Months Training
(Copy of certificate or residency letter)

____40 hours of Mammography CMEs
(Attestation allowed prior to 10/01/1994)
(Copy of residency letter after 10/01/1994)

_____240 mammograms interpreted
in any 6-month period
(Attestation allowed prior to 10/01/1994)
(Copy of residency letter after 10/01/1994)

FINAL
(Initial Qualification met after 04/28/1999)

____ABR, AOBR, or RCPSC
OR Three Months Training
(Copy of certificate or residency letter)

____60 hours of Mammography CMEs
15 hrs in the last 36 months of residency
(Copy of residency letter)

____240 mammograms interpreted
in last 6-month period **OR**
____Certified at 1st allowable time 240 mammograms interpreted in the last 2 years of residency program
(Copy of residency letter)

CONTINUING EXPERIENCE/EDUCATION QUALIFICATIONS

____960 mammograms interpreted in the prior 24 months
(Due 24 months after qualifying date)

____15 Breast specific Category 1 CMEs in the prior 36 months
(Due 36 months after qualifying date)

For State of Texas use:

INITIAL QUALIFICATION START DATE _____
(10/01/1994 or date initial qualification was completed.)

ADDITIONAL MODALITY TRAINING DATE _____
(8 hours initial training in each additional mammographic modality)

☐ FSM ☐ DM

STX Approval _____